Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON PAIN & INJURY
604 PENNY LANE
FRIENDSWOOD TEXAS 77546

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-3327-01

MFDR Date Received
May 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All documentation needed was sent."

Amount in Dispute: $684.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In reviewing Houston Pain & Injury Clinic's exercise logs (submitted by the requestor) for the above referenced dates of service. Per the in and out times, all date of services document 60 minutes of time spent. There are no other references of time spent. Both CPT codes 97110 and 97140 are defined as an 'each 15 minutes' code. According to Centers for Medicare and Medicaid (CMS), payment policies relating to coding, billing, and reporting, 60 minutes allows for 4 units. Please review the original Explanation of Benefits (submitted by the requestor) that shows 4 units of 97110 have been reimbursed for each for the dates of service listed above. The respondent maintains its position that CPT code 97140 was correctly denied in accordance with TDI-DWC rule 134.203. CPT Code 97150 was reimbursed at the fee schedule for both units billed on each date of service listed above. Mtrop9olitan Transit Authority received the request for reconsideration on 5/11/11 via fax. The reconsideration Explanation of Benefits were processed on 5/24/11 and payment was issued on 5/27/11. Per rule 133.250 (f), the reconsideration request was processed and paid within 21 day timeframe allowed. Please see reconsideration Explanation of Benefits in Attachment #1 as well as check documentation in Attachment #2."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2011, March 24, 2011, March 29, 2011, March 31, 2011, April 5, 2011 and April 8, 2011	97140 and 97150	$684.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 11, 2011, April 12, 2011
   - 150 – Payment adjusted because the payer deems the information submitted does not support his level of service.
   - 16 – Documentation does not support billed services

   Explanation of benefits dated April 18, 2011
   - 150 – Payment adjusted because the payer deems the information submitted does not support his level of service.

   Explanation of benefits dated April 26, 2011
   - 16 – Documentation does not support billed services

   Explanation of benefits dated May 24, 2011
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 16 – Documentation does not support billed services

Issues

1. Did the insurance carrier reimburse the requestor for disputed CPT code 97150 for dates of service March 22, 2011, March 24, 2010, March 29, 2011, March 31, 2011, April 5, 2011 and April 8, 2011?
2. Did the requestor submit documentation to support the billing of CPT code 97140?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the insurance carrier's EOB dated May 24, 2011 supports that the insurance carrier issued payment to the requestor for CPT code 97150 rendered on March 22, 2011, March 24, 2010, March 29, 2011, March 31, 2011, April 5, 2011 and April 8, 2011. Payment was issued under check # 299763 and 299764 for the MAR amount of $61.36 per date of service indicated above. The insurance carrier submitted sufficient documentation to support that payment was issued for CPT code 97150 according to 28 Texas Administrative Code §134.203 therefore the disputed issues will not be considered in this review.
2. 28 Texas Administrative Code §134.203 states in pertinent part "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - CPT code 97140 is reimbursement at 15 minute increments. CMS requires that the total treatment minutes, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented.
   - Review of the documentation submitted for review for each disputed date of service does not meet the documentation requirements for timed codes, as a result reimbursement cannot be recommended for CPT codes 97140 rendered on March 22, 2011, March 24, 2010, March 29, 2011, March 31, 2011, April 5, 2011 and April 8, 2011.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 23, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.